Subcommittee: Linkages between CBOs and Integrated Healthcare Organizations
Meeting Minutes
Feb 1, 2018

ATTENDEES:

Tim McGinnin, The Moore Center
Jennifer Pineo, NH Family Voices
Kelly Davies, LifeShare Management Group, LLC
Tina Paquin, Community Crossroads
Wendy Aultman, Bureau of Elderly and Adult Services
Thom O'Conner, Bureau of Elderly and Adult Services
Laura Davie, University of New Hampshire
Krystal Sieradzki, Brain Injury Association of NH
Lavonne Colon, Gateways Community Services

NOTES:

Participating in the learning collaborative subcommittees is a voluntary process; we are not talking about things that are necessarily going to happen. The goal is to get a picture of the landscape. How do we ensure that our CBOs stay healthy active and alive while there are changes at the federal level?

See attached slide deck

We are all representing an organization that will be affected by federal changes. How do we get our CBO's strong enough to weather the storm? Some examples include: setting requirements, CAP, Medicaid Managed Care.

NH is part of 5 states that were chosen to take part in this learning collaborative process by NASUAD. This process is a national effort to help prepare for the incoming managed care implementation. Any ideas we come up with today, we can share with the national group to get technical assistance.

When we did the proposal we were just BDS, but now have been restructured to the Division of Long Term Supports and Services which includes elderly and adult services, and military programs. We are taking these goals and trying to implement them into two different systems (BDS and BEAS). Having everyone at the table is important but a challenge because the systems are different.

CFI sometimes takes a more medical approach; DD system is not considered a medical model. Both can learn from each other. How do we look at the whole person vs just a piece of who they are? We are shooting to meet the goals; they are not drop dead dates.

TODAY'S FOCUS:

Develop linkages between LTSS agencies and integrated health care organizations to improve health outcomes.
NH DSRIP 1115 demonstration waiver was implemented about year ago. NH has been approved to conduct a pilot to see if it works. The purpose is to show if agencies collaborate, there will be better outcomes. There are 7 regions and one IDN (integrated delivery network) is assigned to each region. The agencies only get paid if they achieve the outcomes. IDN counts as an IHO (integrated healthcare organization). Within the demonstration waiver, there are some projects that are required by the CBOs, and some projects that are chosen by each CBO. Some of the goals are more directed to how they interact with other agencies vs the services being delivered. It does target the Mental Health population primarily. It is a payment reform model.

Utilization review and value based contracting are the other two subcommittees with this business acumen. There is also a group working on IT.

How do we incentivize so everyone is encouraged to do a good job? In fee for service there is payment regardless of outcome.

MCOs are looking at Medicaid spend overall not just one piece of it. CMS is looking at one system to look at the persons entire life (residential, day program, employment, pharm spend, health care, etc.)

In order to have one system there needs to be a federal change. The Medicaid and Medicare system are two separate systems. Where is this being thought of and being discussed?

The federal gov is a changing environment. It can change with different administrators.

We can improve on how we look at Medicaid and Medicare data and ensure we are not billing both at the same time and not duplicating services.

For CFI there is a lot of structure there. The case manager looks at Medicaid and Medicare and ensures that they are accessing both systems. DD system is primarily through the waivers. A lot of what we are discussing is in practice in the state already and how do we access that so we do not recreate the wheel. There are pockets of excellence in each waiver that we could build on and incorporate.

Some people who are on CFI should be on ABD and DD. Some are not even on the waitlist because it was just too hard to get on the waitlist.

Is there a need for 4 waivers? Has there ever been a thought to have just one waiver?

ABD and DD mirror each other when it comes to assurances. The Bureau is not closed to streamlining but how do we keep the flavor of what is currently provided?

There has also been talk of creating a waiver for individuals with Autism.

The goal is to not take away resources, it is to work smarter. It's hard when someone is accessing different services and has multiple case managers and has different eligibility requirements and regulations for each system.
There is a general assumption that anyone that is 200k or higher is a high utilizer and has complex needs. The goal is to look at what makes them complex and collaborate between systems to leverage resources.

Question: Is this just waiver funds or waiver and state plan funds? Many understood this was just waiver but should be clarified. Sandy will look into this.

There will be an audit of these service arrangements.

How do we develop a continuum of care for participants? If they go into crisis and then how do we get them back to the services they were receiving before?

There is a pilot project for people in need of intensive treatment services (ITS) that asks providers to report back on certain metrics for people with the highest budgets. Can we do something similar in this project?

Who is doing the enhanced care coordination? This will depend on each case.

Sandy discussed the Emergency Department Protocol for those people are in the emergency department for over 24 hours. This is a recommendation not a requirement. It gets everyone on the same page and requires collaboration between service systems and team members.

Interagency collaboration requires an enormous amount of intentionality and communication to be used in the DD system. There is education that needs to be done because there is an image that Area Agencies (AAs) have unlimited capacity.

Some AAs have had good outcomes having meetings with the hospital teams and talk about individuals that are utilizing the ED. This has helped to build relationships and support when there is an issue. There are partnerships with the hospitals that put communication in place if someone frequents the ED. So there is a phone call to the CM to immediately start the process to put supports in place.

STRATEGIES:

We want to have no more than 3 strategies. Recommendations will come out of this group to create linkages. Want to have this completed by the end of our next meeting.

Medicaid training is being made available to CBOs through the 1115 activities. This will be made available by DHHS.

There are also monthly wrap meetings. This group looks at cases that require interdepartmental collaboration. This group also looks at road blocks and what policy changes need to happen to address the road blocks.

Linkages – Brain Injury Association meets with the MCO's quarterly to discuss high touch clients. Some AAs are looking at doing this well. MCO's are starting to come in and do trainings for families. Service Link facilitates elder wrap meetings. You can bring forward your case to get ideas (it is anonymous for the case they are bringing forward). The true model would have the individual in the room but that rarely happens. Choices for Independence, Adult Protective Services, Hospitals, Elder Law, Service Link, Caregivers, service providers, etc. are all potential participants. These meetings offer the added benefit of networking and building those relationships. The community care team is a similar process.

Care Path regional meetings bring a lot of IDN providers together. Some of this existed before Care Path, but Care Path shored it up. This meeting includes Mental Health, Behavioral Health and the Area Agency. It meets regionally and state wide and us usually quarterly.

CFI has more out of need. There is no AA involved in the delivery of CFI services so everyone has to come together to figure it out. They really try to look at the whole person.

Linkages in the system for children: Families would typically identify that they are the linkage between these systems. In Massachusetts everyone is involved all the time for children, can we look at this system?

The fall off from early intervention to family support: The school system linkage is lacking.

What agencies are the kids involved with in the system? Some agencies might include the AA, MH, Substance Abuse and Department of Children Youth and Families (DCYF). What is the common denominator? They are a child. Is the school the organized delivery system? Probably not but they should be part of the process.

Is a strategy how do we talk to the Special Education department in the state?

If a child has a mental health diagnosis (ADHD, anxiety) are they connected to the Mental Health Agency?

We are not going to solve everything in a day, but these are some questions to consider as we try to identify ways to strengthen the linkages between CBOs and IHOs.

Next Meeting:

March 19, 2018 – 10 am – 12 pm
BDS, Main Building – **second floor, chandler conference room**